STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	**3939 HILLSBORO CIRCLE** **NASHVILLE, TN 37215**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety revisit survey was conducted on 05/06/2019 for all previous deficiencies cited on 02/10/2019. All deficiencies have been corrected, and no new non compliance was found. The facility is in compliance with all regulations surveyed.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445267	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Stories: 3 Construction Type: NFPA, II (000); IBC, II unprotected No plans available on site Constructed: 1989 Sprinklered: Yes Census: 88 Certified beds: 150 A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 02/14/2019. During this Life Safety Survey, Greehills Health and Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on document review, the facility failed to maintain the emergency lighting. The findings included:	K 291	The Emergency lighting test was completed Jan 28, 2019, but failed inspection in due to not lasting 80/90 minutes. A new light has been ordered to replace the failed one. The delivery of this light is expected within the 1st week in March. Once it arrives, the light will be replaced and tested. There are no other emergency lights in the building. A new light was installed at the generator. The maintenance Director has the yearly testing scheduled in the TELS system Results from this testing will be reported during the monthly QAPI meeting.	3/30/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administration | (X6) DATE: 3-7-19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	**3939 HILLSBORO CIRCLE NASHVILLE, TN 37215**

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K 291	Continued From page 1 Document review on 02/10/2019 at 11:10 AM, revealed the facility failed to provide documentation for the annual 90 minute emergency light test during 2018. NFPA 101, 19.2.9.1 (2012 Edition) NFPA 101, 7.9.3.1 (2012 Edition) The Maintenance Director was present when this deficiency was identified and this deficiency was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 291		
K 311 SS=D	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the vertical openings. The findings included: 1. Observation on 02/10/2019 at 12:18 PM, revealed a hole in the door to the South Stairwell on the 1st floor. NFPA 101, 19.3.1 (2012 Edition) NFPA 101, 8.6.5 (2012 Edition) NFPA 101,	K 311	Vertical openings: - Hole in door to south stairwell on first floor. This was repaired on 2/12/19. - Hole in door to north stairwell on first floor. This was repaired on 2/12/19. - First floor north stairwell door did not self-close or self-latch. This was repaired on 2/12/19. - Holes in door frame and wall above door on north 3rd floor stairwell. This was repaired 2/12/19. - The Maintenance Director / designee have inspected the vertical openings in the building for other issues. Corrections have been made.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

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K 311	Continued From page 2 8.3.3.1 (2012 Edition) NFPA 80, 5.2.15.4 (2010 Edition) 2. Observation on 02/10/2019 at 12:42 PM, revealed a hole in the door to the North Stairwell on the 1st floor. NFPA 101, 19.3.1 (2012 Edition) NFPA 101, 8.6.5 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.15.4 (2010 Edition) 3. Observation on 02/10/2019 at 12:43 PM, revealed the door to the 1st floor North stairwell door did not self-close and latch within the frame. NFPA 101, 19.3.1 (2012 Edition) NFPA 101, 8.6.5 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 6.1.4.2.1 (2010 Edition) 4. Observation on 02/10/2019 at 2:50 PM, revealed holes in the door frame and a hole in the wall above the door frame in the North Stairwell on the 3rd floor. NFPA 101, 19.3.1 (2012 Edition) NFPA 101, 8.6.5 (2012 Edition) NFPA 101, 8.3.3.1 (2012 Edition) NFPA 80, 5.2.15.4 (2010 Edition) NFPA 101, 8.2.1.3 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 311	- The Maintenance Director has initiated monthly inspections of vertical openings for 3 months. - The Maintenance Director will report results to the monthly QAPI meeting for this 3 month vertical opening inspection period.	3/30/2019
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321	Hazardous areas and enclosures: - The dry storage room door in the kitchen did not self-close or latch. This was repaired on 2/12/19. The new latch assembly will be installed by 3/15/19. - The therapy storage room door did not self-close and latch. The strike plate was also missing. Both of these items were repaired on 2/13/19.	

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	445267	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

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K 321	Continued From page 3 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations the facility failed to protect the hazardous areas. The findings included: 1. Observation on 02/10/2019 at 11:46 AM, revealed the dry goods storage room did not self-close and latch within the frame. NFPA 101, 19.3.2.1.3 (2012 Edition) 2. Observation on 02/10/2019 at 1:13 PM, revealed the therapy storage room door did not	K 321	- An inspection of other hazardous areas and enclosures has been completed with corrections being made as needed. - The Maintenance Director has initiated monthly inspections of the hazardous areas and enclosures for 3 months. - The Maintenance Director will report results of the hazardous areas and enclosures to the monthly QAPI meeting for 3 months.	3/30/2019

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	445267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	**3939 HILLSBORO CIRCLE NASHVILLE, TN 37215**

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K 321	Continued From page 4 properly self-close and latch within the frame (strike plate was missing). NFPA 101, 19.3.2.1.3 (2012 Edition) The Maintenance Director was present when this deficiency was identified and this deficiency was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324	- The deep fat fryer was found untethered to the wall in the kitchen. Maintenance reconnected Deep fat fryer to the wall on 2/10/19. - The kitchen staff member #1 was educated on proper fire control procedures on 2/18/19. - The maintenance director provided training by 3/06/19 to dietary staff regarding proper fire control procedures, including the manual activation of the hood suppression system and the proper selection of the fire extinguisher.	3/30/2019

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	445267	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/10/2019

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GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

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K 324	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect the cooking facilities. The findings included: 1. Observation on 02/10/2019 at 11:48 AM, revealed the deep fat fryer in the kitchen was mounted on castors and not secured by a restraint device. NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 13.2.3 (2011 Edition) NFPA 54, 9.6.1.2 (2012 Edition) 2. Interview with kitchen staff member #1 on 02/10/2019 at 11:51 AM, revealed the staff member was not knowledgeable of proper fire control procedures for fires under the kitchen hood including the manual activation on the hood suppression system and the proper selection and use of fire extinguishers (kitchen staff member indicated the use of a ABC dry chemical fire extinguisher for extinguishment of a fire in the deep fat fryer). NFPA 101, 19.3.2.5.1 (2012 Edition) NFPA 96, 10.5.7 (2011 Edition) The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 324	- The Dietary Manager/Designee will complete daily inspections of deep fat fryer to ensure that it remains tethered to the wall. Daily inspections are to be completed for an initial 4 week period and then will decrease in frequency to weekly inspections for the following 2 months. - The results of the deep fat fryer inspections will be reported during the monthly QAPI meetings for 3 months.	3/30/2019
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2019**

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GREENHILLS HEALTH AND REHABILITATION CENTER	**3939 HILLSBORO CIRCLE NASHVILLE, TN 37215**

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K 363	Continued From page 6 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to maintain corridor doors.	K 363	- The nourishment room door on 3rd floor contained a hole, which was repaired on 2/16/19. - The Maintenance Director has inspected the corridor doors and has resolved all issues. - The Corridor doors will be inspected on a monthly basis by the Maintenance Director/ designee for 3 months. The results of the inspections will be reported to the Monthly QAPI meetings for 3 months.	3/30/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 363	Continued From page 7 The findings included: Observation on 02/10/2019 at 2:45 PM, revealed holes in the 3rd floor Nourishment room door. NFPA 101, 19.3.6.1 (2012 Edition) The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 363		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations, the facility failed to maintain the utilities. \ The findings included: Observation on 02/10/2019 at 12:48 PM, revealed an open electrical junction box above the ceiling in the corridor outside of the North stairwell on the 1st floor. NFPA 101, 19.5.1.1 (2012 Edition) NFPA	K 511	- There was an open electrical junction box above 1st floor the north stairwell. This was repaired on 3/5/19. - The Maintenance Director/ designee have inspected all other electrical junction boxes in the building. All issues have been resolved or corrected. - A monthly inspection of the building's electrical junction boxes will be completed for 3 months. - The results of the electrical junction box inspections will be reported during the QAPI monthly meeting for 3 months.	3/30/2019

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	445267	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	**3939 HILLSBORO CIRCLE NASHVILLE, TN 37215**

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K 511	Continued From page 8 101, 9.1.2 (2012 Edition) NFPA 70, 314.28 (2011 Edition) The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	K 511		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{E 000}	Initial Comments A Emergency Preparedness revisit survey was conducted on 05/06/2019 for all previous deficiencies cited on 02/10/2019. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed.	{E 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 000	Initial Comments A Emergency Preparedness Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 02/10/2019. During this Emergency Preparedness Survey, Greenhills Health and Rehabilitation Center was not found in substantial compliance with the requirements for participation in Emergency Preparedness Regulations for Long-Term Care Facilities, Federal CFR §483.73. The requirement at 42 CFR, §483.73 are NOT MET as evidenced by:	E 000		
E 024 SS=D	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an	E 024	-Policy OP6 0201.07 Use of Volunteers or Emergency Staffing during Emergencies has been developed and pending Policy & Procedure Committee approval. The policy will be incorporated in the Facility Operations 6 Emergency Preparedness Binder and referenced in the Emergency Plan. -Facility staff members will be educated regarding the use of volunteers and emergency staffing needs during an emergency to address surge and urgent needs. -A copy of the updated Comprehensive Emergency Management Plan has been placed in the red OP6 Emergency Preparedness binders at each nursing station. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	3/30/2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator | 3-7-19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING _____ B. WING _____	02/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 024	Continued From page 1 emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for the use of volunteers in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 02/10/2018 at 3:30 PM, revealed the facility had no record of polices and procedures for the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 024		
E 030 SS=D	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility] must develop and maintain an	E 030		

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E 030	Continued From page 2 emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030	-The names and contact information of service providing entities are included in the Emergency Management Plan as part of the emergency preparedness communication plan. -Facility staff members will be educated on the service providers/entities in case of emergency. -A copy of the updated Comprehensive Emergency Management Plan has been placed in the red OP6 Emergency Preparedness binders at each nursing station. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed. The facility contact list has been updated and will be updated annually.	3/30/2019

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E 030	Continued From page 3 following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include required aames and contact information in the emergency preparedness program per the requirements of Federal CFR §483.73. The findings included: Interview with the maintenance director on 02/10/2019 at 3:40 PM, revealed the facility to provide names and contact information for entities providing services under arrangement in the emergency preparedness communication	E 030		

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E 030	Continued From page 4 plan (vendor information including contact information is located in a binder in the adminastrator's office but not mentioned in the communication plan). The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 030	-The communication plan includes options and/or alternate means of communication with facility staff, Federal, State, and Regional local emergency management agencies in the Emergency Preparedness Program. -Primary means of communication include but are not limited to land line phones, cell phones, overhead paging, walkie-talkies, and internet/email. Staff members have been trained to initiate the phone tree and initiates calls to home and cellphones. -Secondary means of communication include 2 way radio, walkie-talkies, email/internet, Emergency Broadcast systems, Radio and Television systems, and faxed transmission. OP6 0201.02 Communications contains broadcast emergency information to staff and residents and family members. -A copy of the updated Comprehensive Emergency Management Plan has been placed in the red OP6 Emergency Preparedness binders at each nursing station.	
E 032 SS=D	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies in the	E 032		

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E 032	Continued From page 5 emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview with the Maintenance Director on 02/10/2019 at 3:35 PM, revealed the facility had no record of polices and procedures for an alternate means for communicating with Federal, State, tribal, regional, and local emergency management agencies during an emergency. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 032	-The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	3/30/2019
E 033 SS=D	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c), and RHCs/FQHCs under	E 033	-HIPAA policy is followed in the event of an Emergency Management Event leading to transfer to other facility. Continuum of care is secured through the use of the Request and Disclosure table. -Nursing is to remove and protect the medical records in the event of an emergency. Identification stickers, which are securely stored at each nurse's station, would be placed on the medical record of each resident. The receiving facility is responsible for creating a new chart for each resident. Documentation generated during the transfer stay is included in the new chart.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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E 033	Continued From page 6 §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to develop a communication plan that included policies and procedures for methods of sharing information and medical documentation per the requirements of Federal CFR §483.73. . The findings included: Interview with the maintenance director on 02/10/2019 at 3:50 PM, revealed the facility failed to develop policies and procedures for sharing information and medical documentation for patients with other health care providers. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional	E 033	-The old chart and a copy of new chart are combined once the emergency event has subsided and the original new chart is closed and maintained in the medical records. -The pharmacy is to be notified by the facility of changes to resident locations in the occurrence of emergency evacuations. -A copy of the updated Comprehensive Emergency Management Plan has been placed in the red OP6 Emergency Preparedness binders at each nursing station. The staff will be educated by Staff Development Coordinator on the CEMP by 3/15/19 this will be included in the new hire orientation also. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	3/30/2019

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E 033	Continued From page 7 Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 033		
E 034 SS=D	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include policies and procedures for primary and alternate means for communicating with facility staff, Federal, State, regional, and local emergency management agencies in the emergency	E 034	-The communication plan includes options and/or alternate means of communication with facility staff, Federal, State, and Regional local emergency management agencies in the Emergency Preparedness Program. -Primary means of communication include but are not limited to land line phones, cell phones, overhead paging, walkie-talkies, and internet/email. Staff members have been trained to initiate the phone tree and initiates calls to home and cellphones. -Secondary means of communication include 2 way radio, walkie-talkies, email/internet, Emergency Broadcast systems, Radio and Television systems, and faxed transmission. The staff will be educated by Staff Development Coordinator on the CEMP by 3/15/19 this will be included in the new hire orientation also.	

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E 034	Continued From page 8 preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview with the maintenance director on 02/10/2019 at 3:51 PM, revealed the facility did not have an alternate communication plan for the disruption of primary communications with facility staff, Federal, State, regional, and local emergency management agencies during an emergency. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 034	A copy of the updated Comprehensive Emergency Management Plan has been placed in the red OP6 Emergency Preparedness binders at each nursing station. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	3/30/2019
E 035 SS=D	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on records review and interview, the facility failed to develop a communication plan that includes a method for sharing the emergency	E 035	-Facility communication protocols for communicating with families includes three methods: 1) Mass Communication via voice broadcast, 2) Posting at facility, and 3) Facility phone recording. -During the admissions process, the family /responsible party will be educated regarding facility protocol for Commutating with Family members in the event of an emergency. This will be included in the admissions information packet that is provided to the family and patient upon admission.	

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E 035	Continued From page 9 preparedness plan to residents, families and representatives per CFR 483.73 (c). The findings included: Interview with the maintenance director on 02/10/2019 at 3:55 PM, the facility did not provide methods and procedures for sharing information from the emergency plan with residents and their families or representatives. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 035	-The Interdisciplinary Team and Admission Coordinators will be educated on the protocol of communicating with Families in event of emergency. -The protocol for emergency related family communications is included in the Comprehensive Emergency Management plan and is in the red OP 6 Emergency Preparedness binder located in each nursing station. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	
E 036 SS=D	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this	E 036	-The Comprehensive Emergency Management Plans were updated in the OP6 Emergency Prepared binder.	3/30/2019

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E 036	Continued From page 10 section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to include develop and maintain an emergency preparedness training and testing program that is based on the emergency plan in the emergency preparedness program per the requirements of Federal CFR §483.73. The finding included: Interview on 02/10/2019 at 3:59 PM, revealed the facility had no record of polices and procedures for the training and testing program that is based on the emergency plan in the emergency preparedness program . The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional	E 036	-The Staff Development Coordinator has begun educating facility staff on the Comprehensive Emergency Plan. Education will be complete by 3/15/19. -The Comprehensive Emergency Plan will be included in the new hire orientation. -The Maintenance Director/designee will conduct drills to test the plan on an annual basis. -The CEMP (Comprehensive Emergency Management Plan) will be reviewed during the monthly QAPI annually and as needed.	3/30/2019

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E 036	Continued From page 11 Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 036		
E 039 SS=D	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an	E 039	-The facility has joined the Highland Rim Coalition and will be participating in the exercises to test the emergency plan. Staff will be educated by the Staff Development Coordinator that Greenhills Health and Rehab will be participating in the community based drills on an annual basis. By 3/15/19 Results of the community based drills and communication will be reviewed in the monthly QAPI meeting as needed.	3/30/2019

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E 039	Continued From page 12 emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed conduct exercises to test the emergency plan at least annually per the requirements of Federal CFR §483.73(d)(i) and CFR §483.73(d)(ii) . The findings include: Document review and interview with the maintenance director on 02/10/2019 at 04:00 PM, revealed the facility failed to participate in a full-scale community-based exercise. The Maintenance Director was present when these deficiencies were identified and these deficiencies was acknowledged by the Regional	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. BUILDING _____ B. WING _____	02/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENHILLS HEALTH AND REHABILITATION CENTER	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 13 Staff Development Manager and the Rehabilitation Program Director during the exit conference on 02/10/2019.	E 039		